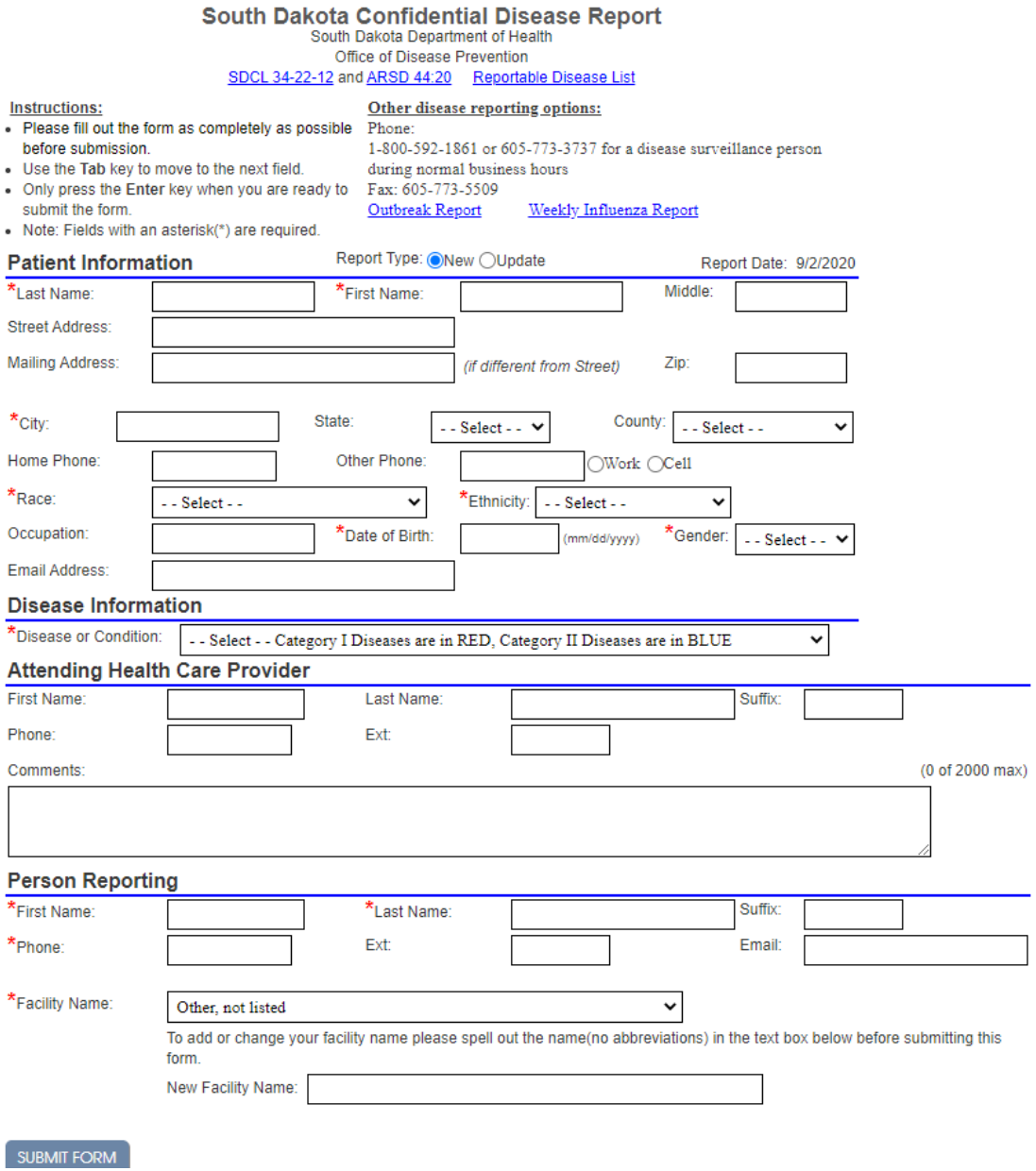

SOUTH DAKOTA
DEPARTMENT OF HEALTH

- CMS National Training Program to Strengthen Nursing Home Infection Control Practices
- Project Firstline - CDC's National Training Collaborative for Healthcare Infection Prevention & Control
- Considerations for Use of SARS-CoV-2 Antigen Testing in Nursing Homes
- 2020-2021 Influenza Vaccination Recommendations and Clinical Guidance during the COVID-19 Pandemic
  - Thursday, August 20



South Dakota Confidential Disease Report
South Dakota Department of Health
Office of Disease Prevention
SDCL 34-22-12 and ARSD 44:20 Reportable Disease List

Instructions:
- Please fill out the form as completely as possible before submission.
- Use the **Tab** key to move to the next field.
- Only press the **Enter** key when you are ready to submit the form.
- Note: Fields with an asterisk(*) are required.

Other disease reporting options:
Phone:
1-800-592-1861 or 605-773-3737 for a disease surveillance person during normal business hours
Fax: 605-773-5509
Outbreak Report Weekly Influenza Report

Patient Information
Report Type: (New) (Update) Report Date: 9/2/2020
*Last Name: *First Name: Middle:
Street Address:
Mailing Address: (if different from Street) Zip:
*City: State: - - Select - - County: - - Select - -
Home Phone: Other Phone: (Work) (Cell)
*Race: - - Select - - *Ethnicity: - - Select - -
Occupation: *Date of Birth: (mm/dd/yyyy) *Gender: - - Select - -
Email Address:

Disease Information
*Disease or Condition: - - Select - - Category I Diseases are in RED, Category II Diseases are in BLUE

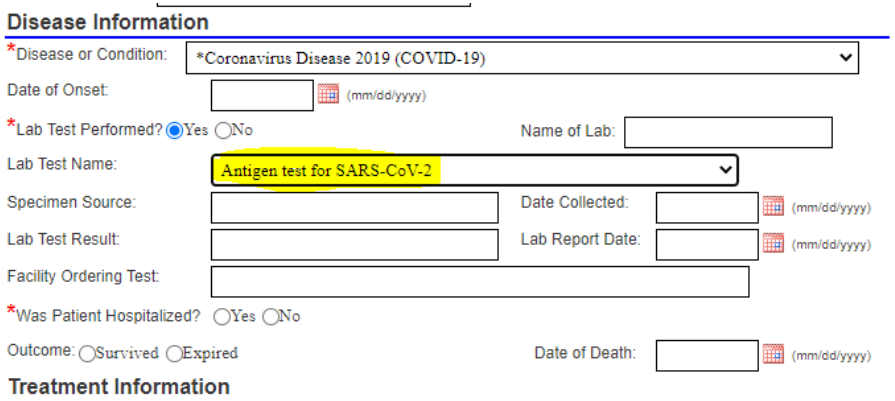
Attending Health Care Provider
First Name: Last Name: Suffix:
Phone: Ext:
Comments: (0 of 2000 max)

Person Reporting
*First Name: *Last Name: Suffix:
*Phone: Ext: Email:
*Facility Name: Other, not listed
To add or change your facility name please spell out the name(no abbreviations) in the text box below before submitting this form.
New Facility Name:

SUBMIT FORM

https://apps.sd.gov/ph93morbidity/secure/index.aspx

- **All** Positive and Negative Antigen tests Need to be reported by facilities
- Fill out as many fields as possible
- Timely data entry – Report immediately
- Click submit – avoid print and fax
  - Secure Form
- Support staff can report this information



Disease Information
*Disease or Condition: *Coronavirus Disease 2019 (COVID-19)
Date of Onset: (mm/dd/yyyy)
*Lab Test Performed? (Yes) (No) Name of Lab:
Lab Test Name: Antigen test for SARS-CoV-2
Specimen Source: Date Collected: (mm/dd/yyyy)
Lab Test Result: Lab Report Date: (mm/dd/yyyy)
Facility Ordering Test:
*Was Patient Hospitalized? (Yes) (No)
Outcome: (Survived) (Expired) Date of Death: (mm/dd/yyyy)
Treatment Information

SOUTH DAKOTA DEPARTMENT OF HEALTH